

HOUSTON INDEPENDENT SCHOOL DISTRICT
Office of Special Education Services
Child Study Department

Request for Reevaluation: Health Information

(To be completed by school nurse, nurse consultant, VI Teacher and/or AI Teacher)

| | | | |
|---|--------------|-------------------------------|------------------|
| Student: _____ | Age: _____ | Sex: _____ | Birthdate: _____ |
| School: _____ | Grade: _____ | Social Security Number: _____ | |
| VISION | | | |
| Date of most recent screening: _____ | | Type of screening: _____ | |
| Name and position of person conducting screening: _____ | | | |
| Results: <input type="radio"/> Corrected <input type="radio"/> Uncorrected | | | |
| <input type="radio"/> <input type="radio"/> As a result of the screening, is there any indication of a need for further assessment, adjustment, or follow-up treatments? If YES, explain: _____ YES NO | | | |
| FOR VISUALLY IMPAIRED/DEAF BLIND ONLY | | | |
| <input type="radio"/> YES <input type="radio"/> NO Is there a need for a new ophthalmological/optometrical report? | | | |
| <input type="radio"/> YES <input type="radio"/> NO FVE (Functional Vision Evaluation) | | | |
| <input type="radio"/> YES <input type="radio"/> NO LMA (Learning Media Assessment) | | | |
| HEARING | | | |
| Date of most recent screening: _____ | | | |
| Name and position of person conducting screening: _____ | | | |
| <input type="radio"/> <input type="radio"/> Passed hearing screening. <input type="radio"/> Left Ear <input type="radio"/> Right Ear YES NO | | | |
| <input type="radio"/> <input type="radio"/> As a result of the screening, is there any indication of a need for further assessment, adjustment, or follow-up treatments? If YES, explain: _____ YES NO | | | |
| FOR HEARING IMPAIRED/DEAF BLIND ONLY | | | |
| <input type="radio"/> YES <input type="radio"/> NO Communication Assessment | | | |
| <input type="radio"/> YES <input type="radio"/> NO Otological | | | |
| <input type="radio"/> YES <input type="radio"/> NO Audiological | | | |
| HEALTH | | | |
| <input type="radio"/> YES <input type="radio"/> NO Does this student exhibit any signs of health or medical conditions? If YES, cite diagnosis and/or observations: _____ | | | |
| <input type="radio"/> YES <input type="radio"/> NO Is this student receiving medication at school? If YES, specify: _____ | | | |
| <input type="radio"/> YES <input type="radio"/> NO Does this student parent report any health or medical conditions or express a concern about a possible medical condition? If YES, specify: _____ | | | |
| <input type="radio"/> YES <input type="radio"/> NO Does this student require adaptive equipment or modifications to the school environment? If YES, specify: _____ | | | |

SIGNATURE OF PERSON COMPLETING THIS SECTION

POSITION

DATE

SIGNATURE OF AI AND VI PERSONNEL

POSITION

DATE